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Clark County Regional Support Network Policy Statement

Policy No.:	**AD04**
Policy Title:	**Payment Process and Fiscal Accountability**
Effective Date:	**September 01, 2001**

Policy: Licensed Mental Health agencies/providers when requesting payment for direct services shall submit invoices according to the terms and conditions of their contracts with the CCRSN/PIHP.

Reference: Washington Mental Health Division RSN Contract, Clark County Provider Contract Agreements.

Procedure:

1. **General Requirements**

   a) Providers are not allowed to pursue payments for services from any Medicaid recipients, unless as otherwise specified under the law [i.e. spend down].

   b) Providers must comply with Section 1128 (b) of the Social Security Act, which prohibits making payments directly or indirectly to physicians or other providers as an inducement to reduce or limit services provided to recipients.

   c) Providers shall submit to the CCRSN/PIHP a copy of their yearly audited financial statements or a copy of their annual audit performed in accordance with OMB A-133. Audited financial information is due within nine months of the end of the agency's fiscal year.

   d) Providers shall submit to the CCRSN/PIHP a Quarterly Financial Report within 30 days of the end of the quarter. The details must include the percentage of administrative costs relative to direct service costs only for contract reimbursement contracts. The BARS Mental Health Supplemental provides the definitions for the expenditure and revenue codes.

   e) Providers are paid monthly on a fee-for-service or block grant basis for all outpatient services.

2. **Third Party Payments**

   a) Providers will ensure that all third-party resources available to RSN funded consumers are identified and pursued in accordance with reasonable collection practices, and in accordance with their contracts with the County.

   b) The Provider will submit a program income/third party payer aggregate report each month, by the 10th, for revenue received in the previous month. Included with that report are the Explanation of Benefits that contain detailed service and payment information by client.

   c) The Provider sends a check for program income received in the previous month to the County, with the EOBs that document the payment for services.

d) Program Income report and EOBs are filed with the invoice. Program income is posted on the County's financial system and tracked within the appropriate fund in accordance with the state's BARS Manual.

e) The financial analyst shall maintain a log of all program income paid to the County by Provider, by payer and by month.

f) The County will monitor the billing and payment practices of each Provider to ensure compliance with this policy.

3. **Payment Process**

a) Refer to Policy AD02 – Performance Monitoring & Payment Calculation

b) Beginning September 1, 2004, IS reports of claims submitted will be sent electronically by the CCRSN/PIHP each week. If data has been entered into IS and is found to be incorrect, an adjustment to the data will be made according to Adjustment Procedures, as outlined in this policy.

4. **Adjustment Procedure**

a) Payments will be adjusted up or down by the CCRSN for the following reasons: duplication of services by providers, incorrect service rate input, incorrect authorization data input, duplication of consumer information, overpayments, repayment of erroneous claims and data transmission problems.

b) The CCRSN will review a sample of consumer charts or billing records every six months to assure that the service documentation matches the billing records. The CCRSN shall notify providers, in writing, the results of the review and any corrective action needed.

c) Providers will update changes to the financial eligibility status of consumers immediately upon change and document the change in the consumer's clinical file or financial record. RSN Information System will reprocess the data changes the same day. These changes will be uploaded to the Mental Health Division at the next weekly submission. A reconciliation of payments due, based on changes in financial status, will be performed every six months, and an adjustment of payments made.

d) Any payment adjustment shall be made in the next month's payment to the agency and indicated on the monthly performance report.

5. **Appeals Process**

a) All requests for an appeal of a payment adjustment must be submitted in writing to the PIHP/CCRSN. Appeals will be accepted only from the Agency's Executive Director or designee. All other requests will be returned to the requesting agency without review.

b) A request for an appeal must include: Name, title and phone number of the authorized person requesting the appeal, description of contested billing, and documentation of services or expenses justifying the billing.

c) A review committee including the department's Deputy Director, the RSN Administrator, the Contract Manager, the Finance Manager, and the Information Systems Manager, will review the appeal. The committee may request additional information from the agency and schedule a meeting with the agency. The agency will be notified in writing within 15

business days of the determination of the committee, once all requested documentation has been received. A denial will include information on the agency's right to further appeal.

d) The CCRSN will log and track all appeal requests.

e) The agency may appeal a denial to the County Auditor's Office for a review of the contested payment. The agency will submit in writing a copy of the original request, the written determination by the Department, and the agency's rebuttal. The Auditor's Office may schedule a meeting with the agency and Department staff. The County Auditor's Office will issue a written determination within 15 business days to the agency and the RSN. This is the final administrative remedy for the agency.

6. **Service and Fiscal Accountability**

a) Providers are expected to comply with the State of Washington's Budget and Reporting System [BARS] and the mental health supplemental effective 7/1/01; and to comply with generally accepted accounting principles [GAAP]. An annual independent audit in compliance with OMB Circular A-133 or any subsequent revisions shall be forwarded to the CCRSN.

b) Monitoring and/or audit visits by the CCRSN or its designee may review financial record keeping to ensure that it meets state and county standards determined to be necessary by an annual risk analysis.

i) Fiscal and program reviews will test for compliance with CCRSN/PIHP policies and procedures, BARS, WACs, RCWs, contract terms and conditions. Provider files and records will be reviewed accordingly.

c) In the event the CCRSN determines that the Provider has failed to comply with any of the WACs, RCWs, the CCRSN Policies and Procedures Manual, or any provision within the Basic Interagency Agreement or Statement of Work, the following corrective action steps will occur:

i) The CCRSN will notify the provider in writing of the nature of the non-compliance issue and require a corrective action plan be submitted.

ii) The Provider has ten (10) working days of receipt of such notification to respond. The Provider shall indicate the action steps being taken to correct the specified non-compliance issue. The corrective action plan shall specify the proposed completion date for correcting the identified non-compliance issue.

iii) If a provider responds with a corrective action plan that is not approved by the CCRSN, an additional response time of five (5) working days will be granted to restructure an approved corrective action plan.

Approved By: Michael Piper CD Date: 11-21-05

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